Criterion 2: Children's Mental Health Data Epidemiology

The plan reports the estimated number of children/youth with severe emotional disturbances in the state (or prevalence rates) and provides for quantitative service targets to be achieved through the implementation of the mental health system of care.

Introduction

Kentucky mental health planners have historically used a five percent prevalence rate estimate for severe emotional disabilities among Kentucky children. Using this estimated rate with 2000 census data, there are approximately 50,000 children with a severe emotional disability among Kentucky's 1,048,660 children.

Kentucky's estimated rate falls in the low range of estimates derived from local studies and cited in "Prevalence of Serious Emotional Disturbance in Children and Adolescence" (Friedman et. al, SAMHSA, 1996). The paper acknowledges the lack of epidemiological data and concludes that regardless of the estimated prevalence rate that may be used, children with severe emotional disabilities are greatly under-served, a conclusion Kentucky planners share.

In Kentucky, criteria for determining whether a child has a severe emotional disability were included in the enabling legislation (KRS 200.503) for the Kentucky IMPACT program in 1990. These criteria include:

- Is under age 18 or under age 21 and was receiving mental health services prior to age 18 and the services must be continued for therapeutic benefit; and
- Has a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that is listed in the current edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders;

And

- Presents substantial limitations which have persisted for at least one year, or are judged by a mental health professional to be at high risk of continuing for one year without professional intervention in at least two of these five areas:

1. Self Care
2. Interpersonal Relationships
3. Family Life
4. Self-Direction
5. Education

Or

- Is a Kentucky resident and is receiving residential treatment for an emotional disability through the interstate compact, or

- Has been removed from the home by the Department for Community Based Services (child welfare agency) and has been unable to be maintained in a stable setting due to a behavioral or emotional disability.

When a child is identified through either process, a marker is placed in the KDMHMRS data system that identifies the child as having SED. Data concerning services received by children with a marker may then be compiled and analyzed.

State Support

KDMHMRS contracts with the Research and Data Management Center (RDMC) at the University of Kentucky to manage the bulk of data it collects. Their data elements include a client demographic data set, a service event data set and a human resources data set. There is also an Adult Outcomes data set that is being established.

To date the IMPACT evaluation system has been housed within the Division of Mental Health and was not linked with the above-mentioned system. The PC-based systems, developed in 1990, to support
the processing and interpretation of Kentucky IMPACT data have proven durable and useful over time. However, as the program has grown in size and there is greater need for integrating and sharing data with regional providers and decision-makers, the goal is to move this evaluation/outcomes system into the larger RMDC managed system. These changes are being made in coordination with the major changes underway for the Department's overall management information system.

Regional Roll Up

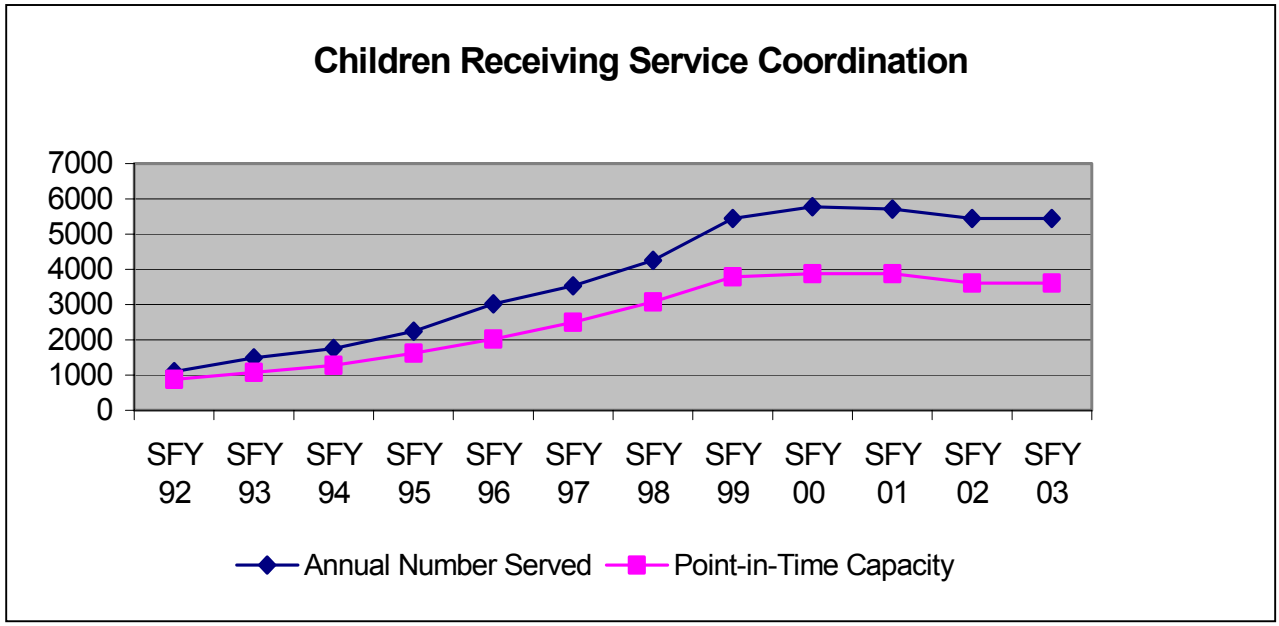
Using 2000 census data and the state's agreed upon prevalence rate estimate of five percent, Regional Boards are aware of the number of children in potential need of services. However, they rely more heavily on indicators and recommendations from the local communities, parent networks and regional planning councils. An annual report, *Kentucky Kids Count*, compiled by the Kentucky Youth Advocates and the Kentucky Population Research at University of Louisville, is also helpful in program planning. (Contact site is www.kyyouth.org.)

Using the eligibility criteria as defined above, a child served by one of Kentucky's Regional Boards may be identified as having SED by the clinician who serves the child based on a combination of the child's diagnosis and the duration and severity of the child's disability. Regional Board staff places a marker in the child's file and transmits it to the KDMHMRS data system. This process accounts for the majority of children in Kentucky who are identified by KDMHMRS as having SED.

A Regional Interagency Council (RIAC) also identifies a child as having a severe emotional disability when it admits him to the Kentucky IMPACT program. In addition to taking into account the diagnosis, duration, and severity of the child's disability, RIACs also consider local priorities for service, service availability, and the child's appropriateness for IMPACT services.

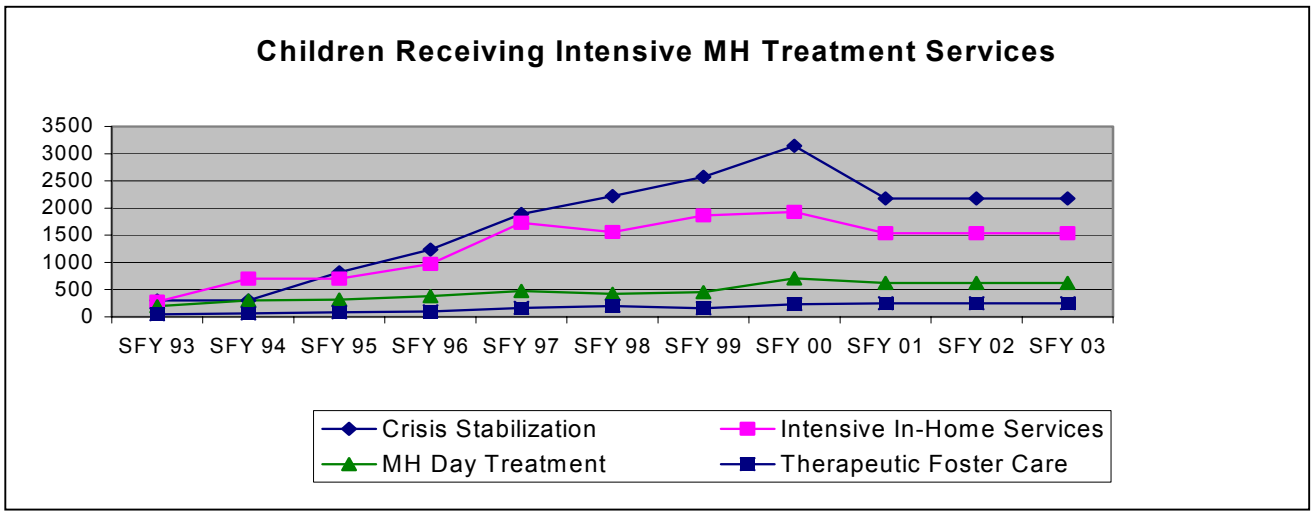
Service Coordination

As described in Criterion 1, Service Coordination is a targeted case management service provided to children with severe emotional disabilities, normally under the auspices of a RIAC. Targeted Case Management is reimbursable to Regional Boards by Kentucky Medicaid and KDMHMRS, and is the core service, along with Wraparound Services, of Kentucky IMPACT. The following chart reflects the growth in RIAC Service Coordination.



Intensive Mental Health Treatment Services

As discussed in Criterion 1, Intensive Mental Health Treatment Services are a vital and growing component of Kentucky's mental health services array for children. The chart below illustrates the growth in Intensive Mental Health Treatment Services over the past decade.



Trends/Challenges

Based on the wide variation of regional penetration rates as charted in Appendix A, it seems evident that the SED marker in the KDMHMRS data set is not consistently applied. Accuracy in coding is addressed during the Department's on-site monitoring of Regional Boards, and statistical indicators that rely on the number of children with an SED marker are increasingly used to assess performance and outcomes. Thus, Regional Boards and the Department are increasingly interested in the consistent and accurate use of the marker in the data sets.

Regional Boards have developed various services to meet the needs of the community and individual children and families that they serve. Many outpatient offices offer services during late afternoon and evening hours. This will keep children who may already be struggling in school from missing instruction in order to receive therapy services. Many clinicians also provide off-site therapy to eliminate barriers such as transportation, childcare for siblings, missed work by parents, etc. Regional board clinicians also offer services at school, in after school daycare centers, homes, or in other community settings. Many formal and informal contracts exist between schools and the Regional Boards to allow for school-based services, the fastest growing component of our children's mental health services array.
All Regional Boards now employ staff with training in services to children aged 0-5.

Planners believe that offering such flexibility in service provision results in a greater number of children and youth receiving needed services. This also moves us towards the goal of reaching children before problems are exacerbated or escalate to crisis. A continual challenge is in the funding of services off-site. The additional costs associated with travel and off-site logistics is sometimes problematic.

Strategies

In August 2002, management of the Kentucky IMPACT data evaluation system shifted from the Division of Mental Health to a collaborative venture with State Interagency Council (SIAC) staff serving as the lead. A state level steering

committee comprised of SIAC and Division staff is working closely with a workgroup of key stakeholders. Their goals are to:

- Evaluate the type of data needed to measure the program's effectiveness considering child and family indicators/outcomes; and
- Identify how best to manage the data so that it can be returned in a timely manner to the regional staff (Service Coordinators and IMPACT program managers) for treatment planning. It is also anticipated that aggregate data will be valuable to those making regional and state level policies that are responsive to programmatic trends.

KDMHMRS continues to process Wraparound Expense data, detailing expense by child and by service category. This information is submitted monthly by the regional IMPACT Programs and the Regional Boards to KDMHMRS. The system supporting the Wraparound Services is called Intensive Family-Based Support Services (IFBSS). With the exception of one region, expense data are submitted via hard copy to KDMHMRS for processing, a time consuming and potentially error-prone process for regional and KDMHMRS staff. Although it will take some time to accomplish, it is desirable to create the ability for all regional programs to electronically submit this information.

Performance Indicators

KDMHMRS selected one indicator to measure the performance of regional systems of care.

Penetration Rate: Percentage of the estimated number of children with severe emotional disabilities who are annually served by a Regional Interagency Council or a Regional Board. Please see Appendix A: Performance Indicators.

Objectives

Regional MH/MR Boards submitted the following Plans for Development in their annual Plan and Budget application with regard to SED prevalence rates.

Region	SED Prevalence Rate
1	Maintain established programming performance within established guidelines, despite the lack of adequate funding.
2	The Pennyroyal Center will increase staffing as required to respond to the increases in referrals for SED services, with the goal of reaching the State penetration rate.
3	Train business office staff on importance of correctly coding priority populations.
4	Maintain current procedures to identifying SED children.
5	Increase number of units delivered for outpatient (clients aged) 0 - 17.
6	To increase by 2% the number of children/youth who receive service coordination.
7	A new tracking system will be established whereby clinicians will be notified on at least a quarterly basis of the clients they do not have in the SED or SED/IMPACT categories and asked if these categories need to be reconsidered.
8	Comprehend will continue to serve above the SED prevalance rate.
9/10	Continue to expand knowledge concerning coding children as SED.
11	To convene 2 meetings with DJJ to increase referrals.
12	All children's clinical staff will receive an updated training outlining the process to capture the correct coding for "SED".
13	The center will continue to strive to obtain accurate information for criteria for SED, priority population to be marked at admission. Status change and at yearly update by June 2004.
14	Maintain at least 70% penetration rate.
15	The SED label will be accurately coded in 90% of the open medical records.

- **Objective C-2-1:** Ensure that children with SED are accurately reflected in KDMHMRS data system through continued analysis of the data received, technical assistance to Regional Board staff, and on-site monitoring.

- **Objective C-2-2:** Implement the Project Management Plan developed in SFY 2003 for the revised Kentucky IMPACT Evaluation system.

Comments from the Planning Council Members at their August 14, 2003 meeting:

There were no comments regarding Criterion 2.